Date Initiated: 6-1-16	**MILWAUKEE COUNTY EMS**	Approved: M. Riccardo Colella, DO, MPH, FACEP
Reviewed/Revised:	**PRACTICAL SKILL**	
Revision:	**VIDEO LARYNGOSCOPE**	Page 1 of 2

Purpose:	**Indications:**
To allow visual insertion of an endotracheal tube To provide positive control of an airway To facilitate assisted ventilation in a patient with inadequate respirations To prevent aspiration in a patient with decreased reflexes	Patients in severe respiratory distress Unconscious patients unable to protect own airway Apnea or inadequate respiratory effort

Advantages:	**Disadvantages:**	**Complications:**	**Contraindications:**
Allows second provider confirmation of tube placement Positive control of the airway Prevents aspiration Facilitates ventilation Provides route for administration of selected medications Facilitates suctioning	Requires special training and equipment May be difficult to avoid C-spine movement Does not prevent gastric regurgitation	Airway trauma Misplacement Esophageal trauma causing hypoxia Potential for simple or tension pneumothorax Gastric dilatation	Patient with intact gag reflex

Pre-use Battery Check

• Press the POWER button (Fig. 1, #4) on the back of the King Vision Display.
• The Display should turn ON immediately. Note: No image will be displayed on the screen without an attached Blade.
- The GREEN LED battery indicator light (Fig. 1, #5) indicates the Display is ready for use. Important: If the LED battery indicator light is FLASHING RED, the batteries must be replaced as soon as possible as a limited amount of battery life remains.

• The Display can be turned "OFF" manually by pressing and holding the POWER button. If a King Vision Blade is not attached to the Display, it will automatically turn off in approximately 20 seconds.
Step by Step Instructions Important: The King Vision Display must be "OFF" before attaching a Blade; otherwise, the video image will become distorted. If this happens, simply turn the Display "OFF" then back "ON".

STEP 1 – Preparing the King Vision Video Laryngoscope (the Display and Blade combination) for use

• Choose the Channeled blade

• Install the Display into the Blade (only goes together one way). Listen for a "click" to signify that the Display is fully engaged with the Blade. Note that the front and back of the parts are color-coded to facilitate proper orientation. In patients with high body mass index, large chest AP diameter, or sometimes with active chest compressions being applied, you may need to insert the blade "headless" and attach display once blade is partially inserted. Alternately, you can insert the blade perpendicular to the nose and rotate device into the midline position.

Using The King Vision Channeled Blade:

The size #3 Channeled blade is designed to be used with standard ETT sizes 6.0 to 8.0. No stylet is needed. Lubricate the ETT, the guiding channel of the Channeled Blade and the distal tip of the Blade using a water soluble lubricant. Take care to avoid covering the imaging element of the blade with lubricant. The ETT may be preloaded into the guiding channel with its distal tip aligned with the end of the channel. Note that the ETT tip should not be evident on the screen when loaded properly.

Step 2 – Powering On

• Press the POWER button (Fig. 1, #4) on the back of the King Vision Display.
• The King Vision Display should turn "ON" immediately AND Display shows a moving image.
• Confirm the imaging of the King Vision is working properly. If not, stop and refer to the "Acquiring an Image" section.
IMPORTANT: If the LED Battery indicator light (Fig. 1, #5) in the upper left hand corner of the King Vision Display is FLASHING RED, the battery life remaining is limited and the batteries should be replaced as soon as possible.

Step 3 – Insertion of King Vision Blade into the Mouth

• Open the patient's mouth using standard technique.
• In the presence of excessive secretions/blood, suction the patient's airway prior to introducing the Blade into the mouth.
• Insert the Blade into the mouth following the midline. Take care to avoid pushing the tongue towards the larynx. In patients with high body mass index, large chest AP diameter, or sometimes with active chest compressions being applied, you may need to insert the blade "headless" and attach display once blade is partially inserted. Alternately, you can insert the blade perpendicular to the nose and rotate device into the midline position.
• As the Blade is advanced into the oropharynx, use an anterior approach toward the base of the tongue. Watch for the epiglottis and direct the Blade tip towards the vallecula to facilitate visualization of the glottis on the Display's video screen. The King Vision Blade tip can be placed in the vallecula like a Macintosh blade or can be used to lift the epiglottis like a Miller blade. For best results, center the vocal cords in the middle of the Display's video screen.
• If the lens becomes obstructed (e.g., blood/secretions), remove the Blade from the patient's mouth and clear the lens.
• Avoid putting pressure on the teeth with the King Vision Video Laryngoscope.

STEP 4 – ETT Insertion

Advance the ETT (Channeled Blade)

OBTAIN THE VIEW AND DO NOT ADVANCE TUBE UNTIL YOU CLEARLY SEE THE OPTIMAL ANATOMY. After you can see the vocal cords in the center of the King Vision Display, advance the ETT slowly and watch for the cuff to pass through the vocal cords. Note that minor manipulation of the blade may be needed to align the ETT tip with the vocal cords.

Troubleshooting Guidelines:

Issue:	Cause:	Correction:
Chest contact during insertion	Obesity, large AP chest diameter, active chest compressions	"Headless" insertion of blade and subsequent attachment of display; turn on obtain view, load endotracheal tube and pass ***OR*** Insert the loaded blade perpendicular to the nose and rotate device into the midline position
View of esophageal intubation (clearly not in trachea)	Blade advanced too deep Holding handle too high	Back tube out to starting position on blade Hold device lower Lift device anteriorly
Tube is lateral to glottis opening and won't turn to pass through glottis	Anatomy	Back tube out to starting position on blade Rotate tube in direction opposite of where the tube is sticking
Realized blade handle is too deep and can't view epiglottis	Overextended the insertion or in too deep	Back tube out to starting position on blade Lift device anteriorly
Camera image obstructed	Mucous or vomit	Remove and clean camera lens Continuous use of suction